Welcome

We are glad you will be visiting soon! Please take some time to review all of these documents prior to your first appointment. This will allow Dr. Gray and Psychological Associates to review all of your information and use your time efficiently during your time together.

Please note that this packet will require you to move through the following steps:

1. download to your computer
2. open the document using any .pdf reading software (i.e. Adobe Acrobat, Apple Preview, etc)
3. type to fill in all of the blanks and sign/type your signature
4. save the newly created document
5. upload back to the portal
6. e-sign the documents

Lastly, If you would like to include any of the previous evaluations completed, please download the next two blank documents and replace them with your documents. Please let us know if you have any questions.

Thank you for taking your time to complete these! We appreciate it and very much look forward to working with you.

Dr. Glori Gray & Psychological Associates
360 North Caswell Road | Charlotte, NC 28204
W: https://drglorigray.com | **P:** (704) 765-2549
E: help@drglorigray.com | **F:** (704) 765-4749

Client's Name _____ **Client's Date of Birth**_____

(Please read carefully.)

POLICIES AND CONSENT FOR PSYCHOLOGICAL TESTING/ASSESSMENT

Background and Credentials of Dr. Glori Gray:

In addition to providing therapy and comprehensive psychological assessments in outpatient settings, I have enjoyed working collaboratively within various multi-disciplinary teams, providing consultation within home and school settings, including early intervention sites. In addition to attaining privileges within an inpatient hospital setting, I have worked within several primary care offices. Since 2002, I have worked as a licensed clinician, first working as a clinical social worker in private practice before leaving North Carolina to complete my doctoral training in clinical psychology in Oregon. I then finished my Residency/Internship and Early Childhood fellowship in clinical child psychology at Alfred I. duPont Hospital for Children. After receiving a license to practice in both Oregon and Virginia, I recently returned to North Carolina where I am a licensed psychologist.

My training as a clinical psychologist involves developing knowledge and expertise in psychological testing and therapy, to understand the interactions between cognition and behavior, and in finding the right solutions for complex situations. I am trained in behavioral and cognitive-behavioral treatment (CBT) with children, adolescents, adults, and families. Specifically, I have had extensive training in trauma-focused cognitive behavioral therapy (TF-CBT), as well as aspects of parent-child interaction therapy and other CBT interventions. Other specific expertise includes child and infant mental health, including the interactions between neuro-cognitive development and behavioral adjustment; attention deficits and related learning issues; sleeping, feeding and related difficulties for toddlers and young children; habit disorders (tics, etc.); autism and other related social difficulties; peer relationship problems (friendships; peer groups; bullying); and the mental health and neuro-developmental loss and grief concerns of young people exposed to trauma.

My mission is to provide individually tailored, sensitive, and empirically validated assessment and treatment approaches that are effective and based on scientific research. Because I value a multidisciplinary approach, I collaborate with other health professionals with whom you would like to be involved in your/your child's care. My training has been specific to pediatric health psychology, and as such, consultation with medical and other collaborative professionals is important to me. Please complete any releases of information so that I might coordinate care with relevant professionals. While I collaborate with medical providers and other professionals, I am not a medical provider and function as a separate entity for service and billing purposes.

Background and Credentials of Sarah Smead, EdS, NCSP, LPA:

In addition to providing therapy and comprehensive psychological assessments in outpatient settings, I have worked collaboratively within multiple school systems as a school psychologist and transition facilitator with the Exceptional Children's Department.

I earned my master's in school psychology in 2009 and my Educational Specialist degree in school psychology in 2010. Since that time, I worked in high schools and middle schools as a school psychologist in both Tucson and outside of Phoenix. While there, I provided comprehensive psychoeducational evaluations, provided individual and group counseling services, and consultation to various school staff on how to best support students with a variety of academic,

social, emotional, neurodevelopmental, and behavioral needs. In 2015, I moved to North Carolina to serve as an Autism Specialist & Clinical Instructor for the University of North Carolina-Chapel Hill TEACCH Autism Program within their Department of Psychiatry. I am currently an Adjunct Clinical Instructor through TEACCH and the Department of Psychiatry as well as an Advanced Consultant with the TEACCH Autism Program.

At TEACCH, I provided a range of intervention services and completed comprehensive psychological assessments for individuals across the lifespan (ranging from toddlers through adulthood). I also had the privilege of working with their training team to provide autism-specific training to educators within North Carolina, various states, and internationally. After leaving TEACCH, I returned to my work as a school psychologist for several years- supporting students across elementary, middle, and high school before transitioning to a role within Charlotte Mecklenburg Schools Exceptional Children's Department on the Behavior Enrichment Services Team. I had the opportunity to continue collaborating with educators and supporting students with a variety of social, emotional, and behavioral needs as well as provide a range of autism-specific consultation and training across the district.

As a result of my training as a school psychologist and my diverse experience as a psychologist in multiple settings, I understand the importance of understanding the range of strengths and needs that an individual may present with and how important it is to include the individual and their values in the process of seeking solutions or answers to their concerns. I am adept at answering complex diagnostic questions, which help my clients fully understand the root cause of their concerns as well as what type of treatment best fits their priorities and needs. I have been trained in Cognitive-Behavioral Therapy, Dialectical Behavior Therapy, brief solution-focused therapy, and strengths-based approaches. I am experienced with implementing a variety of evidence-based practices for autism. I most often utilize antecedent-based interventions, social narratives, visual supports, self-management, and social skills training. I also employ strategies from Structured TEACCHing in both therapeutic and testing sessions in order to support engagement and learn more about a client's individual strengths and needs. I am skilled with using the above methods to build social and emotional skills, self-awareness and self-advocacy skills, as well as support executive functioning, attention and processing differences that neurodivergent individuals may experience.

My mission is to celebrate neurodiversity and individual strengths in order to help clients and their families gain insights and develop supportive next steps. My training and experience has allowed me to participate in a range of multidisciplinary teams including medical providers, mental health professionals, and educators. Through these experiences, I respect the value of collaboration and believe that this is pivotal in fully understanding an individual's needs and developing comprehensive treatment planning for optimal success.

* If you have to cancel for any reason, please recognize that cancellations within 24 hours (**within 10 business days for testing**) will result in a charge for the full time reserved with me. Testing appointments are not refundable unless there is an emergency (defined as a death in the family, significant illness and/or accident). This is with the understanding that I am not able to reserve that time with others who are interested in meeting during that same period. I will extend a 1-time courtesy for therapy appointments in which the child or parent is sick or when there is a true emergency. You are asked to email me in addition to calling the main office, so that I can ensure that you are not charged for the time.

What will happen in a psychological assessment?

If you are interested in testing for you/your child, a psychological evaluation or assessment will involve the use of a variety of techniques and procedures to learn about a young person's psychological traits, strengths, and needs. These procedures include administration of psychological tests, direct observations and interviews with the child, as well as interviews with adults involved in care. The areas of psychological functioning explored include behavioral, emotional, social, cognitive or academic needs. Additionally, skills and methods for intervening at home and in the school are emphasized in assessment and treatment plans.

Psychological evaluations, testing, and therapy can provide an invaluable understanding of your/your child's unique strengths, needs, and functioning. In some circumstances, the extent of our work together – whether in therapy or in testing – may not provide all of the results needed to answer a referral question; at times, results may actually raise additional questions. Also, it is important to understand that our conclusions may differ from other adults' understanding of the child.

Evaluations include assessments of some of (but not limited to) the following challenges: Autism Spectrum including early diagnosis, ADHD, Developmental Disabilities, Learning Disabilities, Mood/Anxiety/Depression, Kindergarten Readiness, Academic Achievement, Developmental progress for infants and toddlers. Our usual testing battery integrates intelligence, educational achievement, learning/memory, language, attention, executive functioning, and psychological and social-emotional functioning. We specialize in administering the Autism Diagnostic Observation Schedule (ADOS) and the Monteiro Interview Guidelines for Diagnosing the Autism Spectrum (MIGDAS) to assess for autism-related concerns.

***Please note: We do not conduct custody assessments, parenting competency assessments for family court proceedings, or consultation/assessment around custodial visitation issues. Because of this, we do not agree to provide expert witness services in family court cases involving questions of custody, parental visitation, or other divorce-related matters.

Risks Involved in psychological assessments or therapy:

With psychological testing, please know that these evaluations require focused mental effort on the part of the child, and some children experience a period of fatigue, irritability, or other signs of tiredness after such testing. In rare circumstances, psychological tests may "trigger" a child's emotional issues, and in such a situation I would work with other providers to plan for the young person's needs and ensure safety.

Please also know that no diagnosis is guaranteed, and there is no guarantee that the client or other involved parties will be happy with the results (i.e., diagnosis and or report of client's functioning). Clinicians cannot and will not skew the report to accommodate the requests of a client or any other involved party, especially when information is contradictory. Psychologists are bound by ethical and legal standards which prohibit them from deleting information that becomes part of the testing record. If it is relevant to the case, it will likely go in the report. While they will do whatever is possible to maintain the confidentiality of their clients as required by law, they may be required to provide information to a court as mandated by a judge. It is with this knowledge that we also understand that some clients may want support for (or to disprove) a specific diagnosis or for their psychologists to report specific information and/or withhold other information. Our ethics require that we provide our professional conceptualization, diagnoses (when necessary) and recommendations given our professional opinions.

Occasionally, mental health providers may incorporate experiential or behavioral interventions that may be helpful in enhancing treatment outcomes for clients. As part of my therapy practice, I may

integrate these interventions in my practice to facilitate behavioral learning and modeling of skills. As such, these optional interventions, potential risks and concerns are noted below. I emphasize building a positive working relationship with the child to make the child comfortable and engaged in the process, particularly when I am working with he or she for a long testing session. My hope is that you/your child will view the process as positive and helpful.

Electronic Communications and Social Media:

Our office uses email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. Occasionally, email may be the best way for us to send you information (e.g., a handout, links to websites). We will only do this with your understanding that email is not secure. Please do not use email to communicate sensitive information to the office. If you do, you assume the risk of disclosure. If you or a child need to discuss a clinical matter, please write it down, speak with our assistant, and/or wait so that this can be discussed during our next session. To protect your privacy, we do not communicate with, or contact, any of my clients through social media. These types of casual social contacts can create significant security risks for clients.

Confidentiality. The information shared with me is considered legally privileged and confidential; typically, information will not be shared with anyone unless the legal guardian has given written authorization for me to do so. There are some exceptions to this confidentiality, when information may be shared without the legal guardian's authorization. For example, Dr. Gray may disclose information without written authorization in the following situations:

- If she is ordered to do so by a court of law;
- If she receives first-hand information about harm done to a child, an elder, a mentally ill adult, or a mentally disabled adult;
- In certain emergency situations;
- When collaborating with another health care provider about the child's immediate needs, including providers at the hospital from which the client was referred.

Please note that *both of a child's legal parents*, whether custodial or not, have the right to access psychological information maintained about a minor child. A comprehensive *Notice of Privacy Practices* is available. This notice explains the Health Insurance Portability and Accountability Act (HIPAA), a federal law providing privacy protections with regard to the use and disclosure of Protected Health Information (PHI).

Fees and Costs. Please see documentation from "Comprehensive Evaluations/Assessments" in section 6 of this packet for more details.

- Fees apply to hours devoted to testing and assessments, specifically:
- Interacting with, observing, and interviewing the child and his/her parents;
- Reviewing any relevant clinical, medical, or educational records;
- Consultation with providers identified in the initial intake as being relevant to the process
- Milieu consultation (possible; as recommended by me in the initial meeting)
- Administering psychological tests, interpreting test results, and preparing the written report;
- Debriefing the results and recommendations with parents, other professionals, and (if indicated) the client him/herself.

By signing below, I agree that I have read, understand, and agree to the statements above.

Guardian's/Client's Signature:_____

Date:_____

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FEES, PAYMENT & INSURANCE

Payment for a consultation is due at the time of the scheduled consultation. To secure two 3-hour testing blocks for comprehensive testing, a reservation payment earned upon receipt is required. Specifically, $1600 is required for Dr. Glori Gray and $1475 for Sarah Smead, M.S., Ed.S.. This is non-refundable payment is applied to the balance held and ensures our time allocated to you and your attendance for testing. The other half is due at the time of the consultation. The amount of hours needed may vary (and therefore the fees) may need to be adjusted and will be discussed at the time of the consultation.

Name of Financially Responsible Party:_____
(Invoices will be billed to this individual.)

Client's Name: _____

Client's Date of Birth: _____

IF YOU ARE USING A PRIVATE HEALTH PLAN TO OFFSET THE COSTS OF SERVICES, please review this statement and sign to accept:

By signing below, I authorize Dr. Gray & Psychological Associates, I understand that Dr. Gray and Psychological Associates is not in-network with any insurance company and I am responsible for checking any pre-authorization requirements and coverage (Starting February 2023) . I understand I will need to provide a copy of any forms required by my insurance by the date of your consultation. I give consent to allow Dr. Gray & Psychological Associates to submit pre-authorizations, when required by the individual insurance company. Further I authorize release of clinical information requested by the health plan to establish "medical necessity" for services and/or to process claims.

Responsible Party's Signature:_____

Date: _____

 Client's Name: _____

STATEMENT OF CONSENT TO SERVICES

By signing below, I indicate I have read (or have had read to me) all of the information contained in this form, and I fully understand this information. In addition, my signature indicates my consent for "client" to participate in psychological testing or therapy services, using Protected Health Information. The information gained from the psychological assessment is to be used for treatment planning purposes during this client's course.

By signing below, I also assume full financial responsibility for fees for psychological testing and/or therapy services provided by Dr. Gray and Psychological Associates. I personally agree to render payment to Dr. Gray and Psychological Associates at the start of services.

Furthermore, this consent can be revoked at any time, although I assume financial responsibility for fees for any services provided prior to revocation of the consent. I am aware of and understand the information contained in the Notice of Privacy Practices, and am aware of my right to access additional copies of this information.

By signing this form, I am agreeing to the terms and conditions stated herein.

Guardian's/ Client's Signature: _____

Date: _____

 Client's Name: _____

CONSENT FOR TELESERVICES

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. Due to COVID-19 protocols, some or all of your services will be offered virtually during this time. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with Dr. Glori Gray and Psychological Associates.

I understand that while psycho-therapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured. I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our sessions could be disrupted or distorted by technical failures, or could be interrupted, or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person treatment and that if my therapist believes I would be better served by another form of psycho-therapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I further attest that since I have chosen this form of treatment, I have been advised that it may not be covered by my insurance company and that I am responsible for any fees incurred during psychotherapy which incorporates telecommunication.

General Considerations:

- Please ensure you are in a private, confidential room to the extent possible, and that others are aware you are in a confidential meeting. It is recommended you hang a sign on your door if you have others in your household who may forget.
- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions. We will use Zoom, and there is a password enabled, as well as a "waiting room" feature to ensure that only those intended for our meeting will be present.
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- Confidentiality still applies for tele-psychology services, and sessions should not be recorded for any reason.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems. We will discuss this at the beginning of our session.
- We need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation. We will discuss this at the beginning of our session.
- If you are under 18, we need the permission of your parent or legal guardian (and their contact information) for you to participate in tele-psychology sessions. They will also sign this agreement below.

Specific considerations for testing:

- The tests we will use through video-conferencing have been determined to be minimally affected by virtual administration, or have been adapted for this purpose. That said, these are unique circumstances and tests have not been validated for in-home use without a trained clinician or technician. All results from virtual testing must be interpreted with these things in mind.
- If we encounter interruptions in our connection, we may not be able to use the testing results from that particular activity or measure.
- To protect testing materials, screen shots, recording, or allowing others to see your screen during testing is strictly prohibited.
- If our connection is interrupted at any time, you are to immediately put away any materials and await further instructions from the examiner. Please do not continue to work on any item while we are disconnected.
- You will be mailed any materials you will need for testing. Do not open these materials until instructed to do so on our call. After testing is complete, you will be asked to seal these in the provided envelope on camera.
- You need to use a computer or full-sized iPad with a video camera for our sessions. It is important to use a computer or regular sized iPad (not a "mini") to ensure the images will appear at their intended size.
- You will need headphones.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi. It is recommended that other household members are not using services that require substantial bandwidth while you are in your testing session.
- As your psychologist, we may determine that due to certain circumstances, tele-psychology is no longer appropriate and that we should resume our sessions in-person once it is possible.

By signing this form, I am agreeing to the terms and conditions stated herein.

Guardian's/ Client's Signature: _____

Date: _____

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COMPREHENSIVE EVALUATIONS/ASSESSMENTS

The process starts with an initial 60-90 minute appointment (parent only for minors). During this session, the testing clinician will gather relevant educational and/or developmental history information. If you have done previous testing, the clinician may review this to determine if results are applicable to this assessment.

The initial battery is developed only after the initial consultation. The testing assessment fees depend on the complexity of the presenting questions/concerns and include all costs such as intake, testing, collateral interviews, review of records, and feedback. The comprehensive fee for Dr. Gray is $3200 and $2950 for Sarah Smead, EdS, NCSP, LPA. This covers approximately 6 hours of testing, the initial intake (90 minutes), as well as the feedback session (90 minutes). This cost includes the intake, test administration, consultation with collaterals, scoring of test results, writing the conceptualization and recommendations, and the feedback session.

For an additional cost, a provider may be available to observe children in their natural milieus, whether that is at school or at home (within a 3-mile radius of this office). Such observations and/or consultation with school personnel regarding assessment results are (an additional) $350/hour. Additional hours of testing beyond the standard 6 are billed at $450/hour (for Dr. Gray) and $400/hr (for Ms. Smead). The need for additional testing will be explained as soon as possible during the testing process. These rare occasions typically require the need for further inquiry of ambiguous clinical findings through additional measures.

Dr. Gray will determine the amount of testing suggested to best serve your needs, which establishes the cost and time required. The process would be either:

ADHD, Educational, and IQ Testing (under 4 hours) — $450/hr for Dr. Gray and $400/hr for Sarah Smead, EdS, NCSP, LPA:

1. Intake Session ($350/90 minutes)
2. Electronic Behavior Rating Forms
3. Diagnostic/Written Report
4. Feedback Session ($350/90 minutes).

Comprehensive Testing - which includes all of the following:

1. Intake Session virtual meeting, 90 minutes)
2. Testing hours (4-6 hours)*
3. Electronic Behavior Rating Forms
4. Document Review
5. Consultation with other providers
6. Teachers interviews
7. Comprehensive Report with any diagnoses and Individualized recommendations
8. Feedback Session (virtual meeting, 90 minutes, which can include youth 12+)

Please note that payment is due at the time testing is scheduled. For instance, if a complete assessment is recommended, the total amount will be due at the completion of your initial appointment. If you do not schedule the testing appointment, the fee for the initial appointment ($350) will be due when you check out. To confirm any testing dates, a "reservation payment"

earned upon receipt of $1600 is required for Dr. Glori Gray and $1475 for Sarah Smead, M.S., Ed.S.. This is non-refundable and applied to the balance held. Once the testing date of service is confirmed, any changes to this date will need to be made **at least 10 business days** in advance of the appointment.
At the time of the SARS-COVID pandemic, testing can be conveniently rescheduled if any one in the family tests positive for the virus and/or if symptoms of fever or respiratory infection are evident between 2 to 3 days before testing. Please note that any reservation payments are not refundable.

Information Regarding Insurance

Insurance may not cover testing if your insurance company considers it to be educational rather than behavioral. We urge you to call your insurance company to verify your out-of-network mental/behavioral health benefits. Also, ask what your coverage would be for a "96136, 96137, 96130, and 93131" billing codes and if there are any pre- authorization requirements.

Once again, you are responsible for checking any pre-authorization requirements and coverage (starting February 2023) . You will need to provide a copy of any forms required by your insurance by the date of your consultation.

By signing this form, I am agreeing to the terms and conditions stated herein.

Guardian's/ Client's Signature: _____

Date: _____

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ABOUT THE EVALUATION PROCESS FOR CHILDREN/ADOLESCENTS

What does the evaluation entail?

- An intake with parents to review background information and assist with individualizing test battery (90 minutes)
- 2-3 testing appointments (2-3 hours each) depending on age, student's processing speed, and emotional/behavioral needs
- A parent conference/feedback session to review any diagnoses, results and recommendations (90 minutes)
- An optional session for older children and teens who wish to understand their results and ask questions (which may involve 30 minutes of the 90 minute feedback session).
- The evaluation fee does not include a school observation session or a meeting with school officials. If you would like these services, we can discuss this separately.

What will you receive?

- A better understanding of your child's intellectual capabilities, learning style, and cognitive and academic strengths and weaknesses, and, as applicable any clinical psychopathology.
- Diagnosis (if applicable)
- Specific recommendations for you and your child as well as teachers, physicians, tutors, and therapists.
- A comprehensive, integrated written report that includes scores, interpretations, and recommendations that will facilitate necessary accommodations in the schools.
- Information on resources, specialists, tutors, tips, and strategies for parents and children and adolescents.

Things to Remember for Testing Day:

- Getting a good night's sleep the night before testing day is important: Please try to keep your child from staying up late, watching scary movies, having caffeine the night before, or deviating from the normal routine.
- Try to have your child eat a good breakfast.
- Medications should be taken as usual on the testing day unless otherwise discussed with your clinician.
- Your child can bring a water bottle and/or snack(s) to sustain energy throughout the day.
- Please bring all completed paperwork (child, parent, and teacher forms).
- Please bring any necessary IEP or 504 plans from school, relevant medical reports, and/or previous testing reports.

 Client's Name: _____

SPECIAL CONTRACT FOR PARENTS WHO ARE SEPARATED, PENDING SEPARATION, DIVORCED OR ENGAGED IN LITIGATION

**If this document does not apply to your family, please go to the end of the section and complete questions. Please write N/A if this does not pertain to your family._____*

When a family is confronted by parental separation or divorce, it is very difficult for everyone, especially children. When the parental relationship is conflictual, it is even more important that clinical sessions presents an emotionally safe environment. Our practice wishes to be clear about our position when parents are separated or divorced. We need your agreement that our involvement will be strictly limited to therapy or evaluations that will benefit your child. We do not provide forensic or custody evaluations. Each parent must sign this form.

Please read this document carefully, and do not hesitate to ask me clarifying questions or to express any concerns you have about these or other materials you have received. Nothing contained in this agreement constitutes legal advice. If you have specific legal questions about this document, and how they may relate to your situation, please seek formal legal advice from an attorney. Each parent must sign this document.

In North Carolina, depending on applicable law and the order of any court, both parents (regardless of who holds sole custody) may have the authority to consult with care or treatment providers for their child and request to inspect their child's relevant treatment records. Though therapeutic/counseling records are not considered psychological records, the non-custodial parent may retain rights to verbal updates and consults. HIPAA regulations permit the covered entity (the doctor or health care facility) to provide or deny access to the records when professional judgment is exercised. Mental health records are kept confidential to protect the child's ability to speak freely about their relationships and concerns regarding each parent. It is rarely in the child's best interest to have clinical records read by parents. Parents are encouraged to meet regularly with their child's therapist. Arrangements can be made to observe appointments, review records in the office, and freely share information regarding the child's health and treatment, as long as such appointments are compliant with applicable law, court orders, and the professional judgment of the treating provider.

Value Statements:

1. The best treatment for children with emotional and behavioral problems is within the context of their families.
2. Children with divorced parents have ongoing developmental needs for regular contact with both parents, unless it can be shown that this contact threatens the child's safety or mental health.
3. Therapy and testing are confidential, but not secret. Parents are entitled to understand the nature of their child's problem as well as the method and course of treatment.
4. Each profession (Medicine, Psychology, Social Work, Marriage and Family Therapy) is respected with its traditions and ethics.

Procedures:

1. Dr. Glori Gray and Psychological Associates requests a copy of the custody decision for the

mental health record, as well as a copy of any court order(s) regarding participation in therapy or evaluations, contact between a minor child and a parent, or provision for payment of medical, evaluation, and therapy bills.

2. Dr. Glori Gray and Psychological Associates will attempt to involve both parents in the child's care except in cases of abuse or serious impairment on the part of one or both parents, or when theinvolvement would be detrimental to the child's mental health or would interfere with the child's treatment.
3. Parents should understand that telephone, face-to-face, e-mail, or written communication from either parent may be shared as is clinically appropriate at the discretion of the therapist, with the other parent or with the child. Written communications, emails and telephone messages become part of the child's permanent record.
4. North Carolina State Law entitles both parents (regardless of who holds sole custody) the authority to consult with any person who may provide care or treatment for the child and to inspect and receive the child's medical, dental and psychological records, to the same extent as the custodial parent may consult with such person and inspect and receive such records. Though therapeutic/counseling records are not considered psychological records, the non-custodial parent retains rights to verbal updates and consults. HIPAA regulations permit the covered entity (the doctor or health care facility) to provide or deny access to the records, when professional judgment is exercised. Mental health records are kept confidential to protect the child's ability to speak freely about their relationships and concerns regarding each parent. It is rarely in the child's best interest to have clinical records read by parents. Parents are encouraged to meet regularly with their child's therapist. Arrangements can be made to observe appointments, review records in the office, and freely share information regarding the child's health and treatment.
5. The parent/guardian who registers the child for services as a client with Dr. Glori Gray and Psychological Associates is established as the guarantor with this agency/provider and is responsible for payment of the account. When parents who are divorced have agreed to share health care expenses, it is the responsibility of the guarantor of the account to pay the fee and to collect reimbursement from the other parent if sharing expenses. If there is a communication problem resulting in a missed appointment, the guarantor is responsible for payment of the missed appointment fee.
6. Dr. Glori Gray and Psychological Associates expects parents to inform each other about scheduled appointments. The no- show fee will apply if an appointment is missed regardless of which parent scheduled the appointment.
7. Dr. Glori Gray and Psychological Associates is not responsible for routine communication with parents who do not attend appointments. For example, Dr. Glori Gray and Psychological Associates cannot routinely contact the non-custodial parent after each appointment. It is unrealistic to expect a therapist to send a summary letter, note, or e-mail after each appointment, unless payment arrangements have been made for this service. Expectation is that parents will communicate with each other openly regarding treatment and that each parent will cultivate a healthy relationship and open communication with their child.
8. Dr. Glori Gray and Psychological Associates welcomes involvement of step-parents, siblings, grandparents, and others, but participation in sessions and access to the professional is determined based on the child's needs, the parents' wishes, and the family's circumstances. Only parents can have access to their child's medical records. Both parents have this right of access, regardless of custody unless the custodial parent provides us with a court order limiting access or communication with Dr. Glori Gray and Psychological Associates.
9. Legal issues may arise after therapy and/or evaluations have begun (for example, if one parent decides to change custody status or if there is an attempt to change custody status). Diagnostic evaluations, therapy, versus legal testimony are different skills and rarely should a clinician be involved in more than one role for an individual client. Dr. Glori Gray and Psychological Associates, clinicians with an established working relationship with a child or family, may refuse to render an

opinion regarding custody, absent some applicable order of a court of competent jurisdiction. A clinician may cooperate with other professionals by providing information, as appropriate. The priority of the clinician shall be to safeguard confidentiality and preserve their ability to continue working in a healing relationship with the child and family.

By signing this form, I am agreeing to the terms and conditions stated herein.

Guardian's/ Client's Signature: _____

Date: _____

Please provide a contact email for the other parent if parents are no longer in the same home. Once again - North Carolina State Law entitles BOTH parents (regardless of who holds sole custody) the authority to consult with any person who may provide care or treatment for the child and to inspect and receive the child's medical, dental and psychological records, to the same extent as the custodial parent may consult with such person and inspect and receive such records. Though therapeutic/counseling records are not considered psychological records, the non-custodial parent retains rights to verbal updates and consults.

Name and email of other parent: _____

Dr. Glori Gray & Psychological Associates
360 North Caswell Road | Charlotte, NC 28204
W: https://drglorigray.com | P: (704) 765-2549
E: help@drglorigray.com | F: (704) 765-4749

 Client's Name: _____

COVID-19 IN-OFFICE APPOINTMENT CLIENT INFORMED CONSENT AND WAIVER

This document contains important information about the decision to resume in-person services in light of the public health crisis caused by COVID-19. Please read this agreement carefully and let your provider know if you have any questions.

DECISION TO MEET FACE TO FACE

Thank you for your trust in our practice. By signing this consent form I am agreeing to meet in person for all or some future sessions. Given the benefits, and inherent risks, in conducting in-person services while COVID-19 remains an active contagion in our society, we wish to address the ways in which we are working to mitigate risk of infection at our offices. We strive to protect you and our staff via hygiene and infection control practices informed by the CDC, EPA, OSHA, WHO, and other guiding organizations. We also ask that you engage in infection control practices to contribute to the health and safety of in-person services, and that you recognize that you are voluntarily choosing to seek in-person services with knowledge of the inherent risks of infection. In addition, at any time, you may speak to your provider if you wish to return to Teletherapy appointments.

OUR PLAN FOR OFFICE SAFETY

Dr. Glori Gray and Psychological Associates takes the health and safety of clients and staff members very seriously. We strive to provide excellent clinical services in the safest possible environment by taking the following measures:

- Clients who are ill will be asked not to come in to our offices. Staff members who show any symptoms of a contagious illness, or who have been in contact with those showing symptoms of COVID-19, or testing positive for COVID-19, will be required to stay home.
- Hygiene Practices: Our staff will be practicing infection control hygiene practices, including covering coughs and sneezes, and frequent hand washing.
- Shared Items: We have removed commonly touched items to help minimize transmission of the virus, such as magazines in the waiting room and pillows in clinician offices.
- Frequent Sanitizing: Common areas and equipment, such as door knobs, will be sanitized throughout the day, offices will be sanitized between sessions, and clinician and testing materials (e.g,. chairs, tables, waiting room, toys, desks) will be sanitized between use, per CDC guidelines.

YOUR RESPONSIBILITY FOR PROTECTING YOURSELF AND OTHERS

- If you, a family member, or anyone that you have been in contact with in the past 14 days have had symptoms of COVID-19, including fever/chills, coughing, shortness of breath, muscle pain, and/or sore throat, OR tests positive for COVID-19, please do not plan to come into the office. We ask that you take your/your child's temperature at home prior to coming into the office. Anyone with a temperature above normal are asked to reschedule your appointment or change to a Teletherapy session.
- Hygiene: You are encouraged to use bathrooms to wash hands upon arriving for your appointment, hand sanitizer will be available in all rooms, and we ask that clients refrain from touching faces, and maintain social distancing, where possible.

IDENTIFICATION AND NOTIFICATION OF EXPOSURE TO COVID-19

Although we are making every reasonable effort to manage infection risk, and believe that most clients are doing the same, we recognize that some individuals with the virus remain asymptomatic and that there is no way to guarantee that those entering our offices will not be exposed to COVID-19. For public health protection, we ask that any client who has been in our offices and subsequently experiences symptoms of COVID-19, or has been exposed to another person with symptoms of COVID-19, please notify our office immediately so that we can take any additional infection control measures and notify others who have been exposed.

Should we learn that any staff member, client, or household member of anyone who has been in our office has symptoms of COVID-19 or tests positive for the COVID-19 virus, we will notify all individuals who have been in our office in the same time frame of the potential that they may have been exposed. Notifications will be provided to those who had been in our offices and may have come into close contact on the day that the infected individual was also in that office. We will not disclose names or the role of the person infected (e.g., client, janitorial staff, therapist) in an effort to protect confidentiality and privacy.

COVID-19 PROTOCOL COORDINATOR

MariaPaula Chin is our COVID-19 office administrator. She is the contact person to address any questions or concerns and can be reached at 704.765.2549 or help@drglorigray.com. Please contact Maria immediately to report any exposure to or positive test of the COVID-19 virus.

DISCLAIMER

We have procedures in place to mitigate risk per recommended guidelines. However, as with the transmission of any communicable illness, you can still be exposed to COVID-19 at any time. By signing below, you agree to hold Dr. Glori Gray and Psychological Associates harmless in the event that you, or anyone exposed by you, becomes ill with the COVID-19 virus.

By signing this form, I am agreeing to the terms and conditions stated herein.

Client's Signature: _____

Date: _____

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Dr. Glori Gray & Psychological Associates

Authorization for Disclosure Form

This form when completed and signed by you, provides authorization for Dr. Glori Gray & Psychological Associates (DGA) to release/receive protected information from your clinical record to/from the person(s) designated within the document.

Client's Name _____ Client's DOB: _____

I authorize _____ and/or his/her administrative and clinical staff (cross out if not applicable)
(DGA Cllinician Name)

to release or receive the following information from the records of the above listed client for services provided during the time period of **the last year (or as otherwise relevant)** _____.

Please CHECK item(s) to indicate specific authorization:

☐ Evaluation Report	☐ Test Results/Report	☐ Treatment Summary	☐ Treatment Plan
☐ Progress to date	☐ Symptoms	☐ Diagnosis	☐ Prognosis
☐ Other (describe):	☐ Behavioral checklists narrative form and/or description		☐ Functional Status

_____ _____

This information should only be released to or received from:

Name: *PEDIATRICIAN*
Organization: _____
Address: _____
_____
Phone: _____
Email _____

Name: _____
Organization: Dr. Gray & Psychological Associates
Address: 360 N. Caswell Rd
Charlotte, NC 28204
Phone: 704.765.2549
Fax: _____

I am requesting my therapist to release or receive this information for the following reason(s): *("at the request of the individual"* is all that is required if you are the client and do not desire to state a specific purpose)
_____.

This authorization shall remain in effect until _____ (expiration date) or until 1 year from now. _____
(event related to the individual or the purpose of the use or disclosure)

You have the right to revoke this authorization, in writing, at any time by sending such written notification to DGA's office address. However, your revocation will not be effective to the extent that DGA has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

Client Signature	***Printed Name***	***Date***
Guardian Signature	***Printed Name***	***Date***

Dr. Glori Gray & Psychological Associates

Authorization for Disclosure Form

This form when completed and signed by you, provides authorization for Dr. Glori Gray & Psychological Associates (DGA) to release/receive protected information from your clinical record to/from the person(s) designated within the document.

Client's Name _____ Client's DOB: _____

I authorize _____ and/or his/her administrative and clinical staff (cross out if not applicable)

(*DGA Cllinician Name)*

to release or receive the following information from the records of the above listed client for services provided during the time period of **the last year (or as otherwise relevant)** _____**.**

Please CHECK item(s) to indicate specific authorization:

☐ Evaluation Report	☐ Test Results/Report	☐ Treatment Summary	☐ Treatment Plan
☐ Progress to date	☐ Symptoms	☐ Diagnosis	☐ Prognosis
☐ Other (describe): _____	☐ Behavioral checklists narrative form and/or description _____		☐ Functional Status

This information should only be released to or received from:

Name: *SCHOOL NAME*

Organization: _____

Address: _____

_____

Phone: _____

Email _____

Name: _____

Organization: Dr. Gray & Psychological Associates

Address: 360 N. Caswell Rd
Charlotte, NC 28204

Phone: 704.765.2549

Fax: _____

I am requesting my therapist to release or receive this information for the following reason(s): *("at the request of the individual"* is all that is required if you are the client and do not desire to state a specific purpose)

_____.

This authorization shall remain in effect until _____ (expiration date) or until 1 year from now. _____

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Client Signature	***Printed Name***	***Date***
Guardian Signature	***Printed Name***	***Date***

Dr. Glori Gray & Psychological Associates

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Client's Name _____ Client's DOB: _____

I authorize _____ and/or his/her administrative and clinical staff (cross out if not applicable)

(*DGA Cllinician Name)*

to release or receive the following information from the records of the above listed client for services provided during the time period of **the last year (or as otherwise relevant)** _____**.**

Please CHECK item(s) to indicate specific authorization:

☐ Evaluation Report	☐ Test Results/Report	☐ Treatment Summary	☐ Treatment Plan
☐ Progress to date	☐ Symptoms	☐ Diagnosis	☐ Prognosis
☐ Other (describe):	☐ Behavioral checklists narrative form and/or description		☐ Functional Status

_____ _____

This information should only be released to or received from:

Name: *REFERRING PROVIDER*

Organization: _____

Address: _____

_____

Phone: _____

Email _____

Name: _____

Organization: Dr. Gray & Psychological Associates

Address: 360 N. Caswell Rd
Charlotte, NC 28204

Phone: 704.765.2549

Fax: _____

I am requesting my therapist to release or receive this information for the following reason(s): *("at the request of the individual"* is all that is required if you are the client and do not desire to state a specific purpose)

_____.

This authorization shall remain in effect until _____ (expiration date) or until 1 year from now. _____

(event related to the individual or the purpose of the use or disclosure)

You have the right to revoke this authorization, in writing, at any time by sending such written notification to DGA's office address. However, your revocation will not be effective to the extent that DGA has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

Client Signature	***Printed Name***	***Date***
Guardian Signature	***Printed Name***	***Date***

Thank you!

Thank you for your time with this! We really appreciate it and look forward to working with you! If you have any questions or concerns, please do not hesitate to contact our office.

Please do not forget to complete the Client Developmental History Form. Go to this link to access it: https://forms.gle/Y3HFFgrWzmyrzrxB6 -as well as the documents on the portal (which include documents related to insurance filing and any previous testing).

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